

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

There will be a per-page fee charged for Record requests.

1. I hereby authorize the following BHS Facilities (please check all that apply):

- Butler Memorial Hospital
 Primary Care Associates
 Clarion Hospital
 Butler Medical Providers: Please list each physician or physician's office

to release information from the record of:

Patient Name _____ Birth Date _____ Unit Number _____
 to the following: _____

Name of Facility/Person

Phone

Fax

2. Records are requested for the purpose of (please check one):

- Medical Treatment/Continued Care
 Insurance
 Legal
 Personal Use
 Other: _____

Parts 1 and 2 must be completed to properly identify the records to be released.

3. Format of Records Requested: () Paper Copies () Electronic Media (unencrypted)
4. Types of Records to be released and date(s) of service (Please check all that apply)

- Inpatient: Dates _____ Outpatient testing-Dates _____
 Emergency Dept-Dates _____ Same Day Surgery-Dates _____
 Butler Medical Provider Physician Office Records-Dates _____

5. Specific Information to be released (check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> History/Physical | <input type="checkbox"/> Mammography Report | <input type="checkbox"/> Cardiology Report |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Nurses' Notes | <input type="checkbox"/> Physician's Orders |
| <input type="checkbox"/> Radiology | <input type="checkbox"/> Medication Administration Records | <input type="checkbox"/> Progress Notes/Office Notes |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Operative Report | <input type="checkbox"/> Discharge Instructions |
| <input type="checkbox"/> Laboratory Reports/Test | <input type="checkbox"/> Pathology Report | <input type="checkbox"/> Emergency Department Records |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Slides | <input type="checkbox"/> Films |

6. HIV, Mental Health and Drug & Alcohol/Information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.

Do not release:
 HIV
 Mental Health/Psychiatric
 Drug & Alcohol

7. I understand that this Authorization is effective for a six (6) month period from the date of signature unless otherwise specified. I understand that I may revoke this authorization in writing at any time except to the extent that Butler Health System or its affiliates or their respective employees or agents have acted upon this authorization. My written revocation must be submitted to the Privacy Officer, Butler Health System.

See side two of this form for additional patient rights and responsibilities.

Patient Signature (14 years of age or older may authorize release of mental health information. A non-emancipated minor may authorize release of drug and alcohol treatment information)

Date/Time

Signature of Authorized Representative

Date/Time

*Status of Authorized Representative (Proper paperwork required);

- Parent/Legal Guardian
 Power of Attorney
 Next of Kin
 Executor of Estate

(Initial)- I authorize BHS facility to mail this information to the address above.

ORAL AUTHORIZATION (for persons physically unable to sign)
NOT Applicable to HIV Related Information or Drug & Alcohol Treatment Information

I witness that the patient understood the nature of this release and freely gave their oral authorization. (Two witnesses required)

Reason patient Unable to Sign Consent: _____

Witness Signature

Date/Time

Witness Signature

Date/Time

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Additional Patient Rights and Responsibilities

- A disclosure statement, as required by law, will accompany all records released
- Any drug or alcohol treatment records released will have the following statement accompany the records; "This information has been disclosed to you from records protected by federal confidentiality rules."
- Release of my record will be for the purpose stated on this form. Only those items checked off or listed will be released.
- Although applicable law may prohibit re-disclosure of these records. I understand that it is possible that the facility/person
- That received the records may re-disclose the information, therefore 1) BHS and its affiliates, and their respective staff/employees have no responsibility or liability as a result of any re-disclosure and, 2) such information would no longer be protected by the Privacy Rule.
- I understand and authorize the release of records to the individual referenced herein using non-encrypted electronic media and that information on CD-ROM is not password protected. I understand and agree that neither BHS nor its affiliates, nor their respective staff/employees have any responsibility or liability if the protective health information is breached due to the media not being encrypted or being accessed by an unauthorized individual.
- My decision to revoke the Authorization may result in my insurance company not being able to pay for my medical care and I understand that I may be responsible for payment of the claim.
- I understand that I am no required to sign this Authorization in order to receive treatment.
- In accordance with 4 PA Code 255.5 (b). Drug and Alcohol treatment information to be released to judges, probation or parole officers, insurance companies, health or hospital plan(s) or government officials shall be restricted to the following:
 1. Whether the client is or is not in treatment
 2. The prognosis of the client
 3. The nature of the program
 4. A brief description of the progress of the client
 5. A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse
- I am entitled to a copy of this completed Authorization form

Hospital/Office use only:

Identity verified by Photo ID

Individual releasing records

Print Name clearly _____

Signature

Date/Time

03-18-22 dlm